FOR OHF USE

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2004
STATE OF ILLINOIS
DEPARTMENT OF PUBLIC AID
FINANCIAL AND STATISTICAL REPORT FOR
LONG-TERM CARE FACILITIES
(FISCAL YEAR 2004)

IMPORTANT NOTICE
THIS AGENCY IS REQUESTING DISCLOSURE OF INFORMATION THAT IS NECESSARY TO ACCOMPLISH THE STATUTORY PURPOSE AS OUTLINED IN 210 ILCS 45/3-208. DISCLOSURE OF THIS INFORMATION IS MANDATORY. FAILURE TO PROVIDE ANY INFORMATION ON OR BEFORE THE DUE DATE WILL RESULT IN CESSATION OF PROGRAM PAYMENTS. THIS FORM HAS BEEN APPROVED BY THE FORMS MANAGEMENT CENTER.

I. IDPH Facility ID Number: 0008524

Facility Name: Fairview Haven

Address: 605-609 North Fourth Street (Number) Fairbury (City) 61739 (Zip Code)

County: Livingston

Telephone Number: (815) 692-2572 Fax # (815) 692-4257

IDPA ID Number: 37-0814781001

Date of Initial License for Current Owners: 1962

Type of Ownership:

x	VOLUNTARY,NON-PROFIT		PROPRIETARY		GOVERNMENTAL
x	Charitable Corp.		Individual		State
	Trust		Partnership		County
IRS Exemption Code 501 (c) 3			Corporation		Other
			"Sub-S" Corp.		
			Limited Liability Co.		
			Trust		
			Other		

In the event there are further questions about this report, please contact:
Name: Rick Plattner Telephone Number: (815) 692-2572

II. CERTIFICATION BY AUTHORIZED FACILITY OFFICER

I have examined the contents of the accompanying report to the State of Illinois, for the period from 7/1/2003 to 6/30/2004 and certify to the best of my knowledge and belief that the said contents are true, accurate and complete statements in accordance with applicable instructions. Declaration of preparer (other than provider) is based on all information of which preparer has any knowledge.

Intentional misrepresentation or falsification of any information in this cost report may be punishable by fine and/or imprisonment.

Officer or Administrator of Provider

(Signed) _____ (Date)

(Type or Print Name) Rick Plattner

(Title) Administrator

Paid Preparer

(Signed) _____ (Date)

(Print Name and Title)

(Firm Name & Address)

ROBERT REIN
Certified Public Accountant
P.O. Box 201, Morton, Illinois 61550-0201 309-266-8178

(Telephone) ( )

MAIL TO: OFFICE OF HEALTH FINANCE
ILLINOIS DEPARTMENT OF PUBLIC AID
201 S. Grand Avenue East
Springfield, IL 62763-0001 Phone # (217) 782-1630

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

III. STATISTICAL DATA

A. Licensure/certification level(s) of care; enter number of beds/bed days, (must agree with license). Date of change in licensed beds _____

	1 Beds at Beginning of Report Period	2 Licensure Level of Care	3 Beds at End of Report Period	4 Licensed Bed Days During Report Period	
1	63	Skilled (SNF)	63	23,058	1
2		Skilled Pediatric (SNF/PED)			2
3		Intermediate (ICF)			3
4		Intermediate/DD			4
5		Sheltered Care (SC)			5
6		ICF/DD 16 or Less			6
7	63	TOTALS	63	23,058	7

B. Census-For the entire report period.

	1 Level of Care	2 Patient Days by Level of Care and Primary Source of Payment: Public Aid Recipient	3 Private Pay	4 Other	5 Total	
8	SNF	26	373	382	781	8
9	SNF/PED					9
10	ICF	8,752	12,997		21,749	10
11	ICF/DD					11
12	SC					12
13	DD 16 OR LESS					13
14	TOTALS	8,778	13,370	382	22,530	14

C. Percent Occupancy. (Column 5, line 14 divided by total licensed bed days on line 7, column 4.) 97.71%

D. How many bed-hold days during this year were paid by Public Aid?
42 (Do not include bed-hold days in Section B.)

E. List all services provided by your facility for non-patients.
(E.g., day care, "meals on wheels", outpatient therapy)
Apartment & Condominium Rental for Elderly

F. Does the facility maintain a daily midnight census? Yes

G. Do pages 3 & 4 include expenses for services or investments not directly related to patient care?
YES [X] NO [ ]

H. Does the BALANCE SHEET (page 17) reflect any non-care assets?
YES [X] NO [ ]

I. On what date did you start providing long term care at this location?
Date started 10/28/62

J. Was the facility purchased or leased after January 1, 1978?
YES [ ] Date 10/28/62 NO [X]

K. Was the facility certified for Medicare during the reporting year?
YES [X] NO [ ] If YES, enter number of beds certified 21 and days of care provided 382

Medicare Intermediary Administar

IV. ACCOUNTING BASIS

ACCRUAL [x] MODIFIED CASH* [ ] CASH* [ ]

Is your fiscal year identical to your tax year? YES [X] NO [ ]

Tax Year: 30-Jun-04 Fiscal Year: 30-Jun-04

* All facilities other than governmental must report on the accrual basis.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (throughout the report, please round to the nearest dollar)

	Operating Expenses	Costs Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	A. General Services	1	2	3	4	5	6	7	8	9	10	
1	Dietary	259,239	14,923	7,328	281,490		281,490		281,490			1
2	Food Purchase		166,790		166,790		166,790	(16,108)	150,682			2
3	Housekeeping	88,487	19,632		108,119		108,119		108,119			3
4	Laundry	65,801	13,258		79,059		79,059		79,059			4
5	Heat and Other Utilities			95,843	95,843		95,843	(34,501)	61,342			5
6	Maintenance	144,256	80,127	13,915	238,298		238,298	(4,656)	233,642			6
7	Other (specify):*											7
8	TOTAL General Services	557,783	294,730	117,086	969,599		969,599	(55,265)	914,334			8
	B. Health Care and Programs											
9	Medical Director			4,400	4,400		4,400		4,400			9
10	Nursing and Medical Records	1,194,080	46,704	69,357	1,310,141	(2,214)	1,307,927		1,307,927			10
10a	Therapy	71,858		8,141	79,999		79,999		79,999			10a
11	Activities	52,188	7,611	7,488	67,287		67,287		67,287			11
12	Social Services	36,347		1,001	37,348		37,348		37,348			12
13	Nurse Aide Training			2,883	2,883	2,214	5,097		5,097			13
14	Program Transportation			3,112	3,112		3,112		3,112			14
15	Other (specify):*											15
16	TOTAL Health Care and Programs	1,354,473	54,315	96,382	1,505,170		1,505,170		1,505,170			16
	C. General Administration											
17	Administrative	60,643			60,643		60,643		60,643			17
18	Directors Fees											18
19	Professional Services			37,039	37,039	(202)	36,837	(13,550)	23,287			19
20	Dues, Fees, Subscriptions & Promotions			10,183	10,183	105	10,288	(1,268)	9,020			20
21	Clerical & General Office Expenses	95,708	5,737	37,800	139,245	(2,103)	137,142	(4,328)	132,814			21
22	Employee Benefits & Payroll Taxes			412,668	412,668	47,285	459,953		459,953			22
23	Inservice Training & Education			1,640	1,640		1,640		1,640			23
24	Travel and Seminar			12,028	12,028	1,233	13,261	(2,487)	10,774			24
25	Other Admin. Staff Transportation											25
26	Insurance-Prop.Liab.Malpractice			155,890	155,890	(46,244)	109,646		109,646			26
27	Other (specify):*											27
28	TOTAL General Administration	156,351	5,737	667,248	829,336	74	829,410	(21,633)	807,777			28
29	TOTAL Operating Expense (sum of lines 8, 16 & 28)	2,068,607	354,782	880,716	3,304,105	74	3,304,179	(76,898)	3,227,281			29

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

NOTE: Include a separate schedule detailing the reclassifications made in column 5. Be sure to include a detailed explanation of each reclassification.

Facility Name & ID Number Fairview Haven, Inc. #0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

V. COST CENTER EXPENSES (continued)

	Capital Expense	Cost Per General Ledger				Reclass-ification	Reclassified Total	Adjust-ments	Adjusted Total	FOR OHF USE ONLY		
		Salary/Wage	Supplies	Other	Total							
	D. Ownership	1	2	3	4	5	6	7	8	9	10	
30	Depreciation			141,938	141,938		141,938	(12,623)	129,315			30
31	Amortization of Pre-Op. & Org.											31
32	Interest			18,438	18,438	(224)	18,214	(18,214)				32
33	Real Estate Taxes			565	565		565	(565)				33
34	Rent-Facility & Grounds											34
35	Rent-Equipment & Vehicles			626	626		626		626			35
36	Other (specify):*											36
37	TOTAL Ownership			161,567	161,567	(224)	161,343	(31,402)	129,941			37
	Ancillary Expense											
	E. Special Cost Centers											
38	Medically Necessary Transportation											38
39	Ancillary Service Centers		12,998	482	13,480	150	13,630		13,630			39
40	Barber and Beauty Shops			3,098	3,098		3,098		3,098			40
41	Coffee and Gift Shops			4,377	4,377		4,377		4,377			41
42	Provider Participation Fee			34,588	34,588		34,588	(1)	34,587			42
43	Other (specify):*			7,663	7,663		7,663	(7,663)				43
44	TOTAL Special Cost Centers		12,998	50,208	63,206	150	63,356	(7,664)	55,692			44
45	GRAND TOTAL COST (sum of lines 29, 37 & 44)	2,068,607	367,780	1,092,491	3,528,878		3,528,878	(115,964)	3,412,914			45

*Attach a schedule if more than one type of cost is included on this line, or if the total exceeds $1000.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

VI. ADJUSTMENT DETAIL

A. The expenses indicated below are non-allowable and should be adjusted out of Schedule V, pages 3 or 4 via column 7. In column 2 below, reference the line on which the particular cost was included. (See instructions.)

	NON-ALLOWABLE EXPENSES	1 Amount	2 Refer-ence	3 OHF USE ONLY	
1	Day Care	$		$	1
2	Other Care for Outpatients				2
3	Governmental Sponsored Special Programs				3
4	Non-Patient Meals	(14,821)	2.2		4
5	Telephone, TV & Radio in Resident Rooms				5
6	Rented Facility Space				6
7	Sale of Supplies to Non-Patients				7
8	Laundry for Non-Patients				8
9	Non-Straightline Depreciation	6,084	30.3		9
10	Interest and Other Investment Income	(5,355)	32.3		10
11	Discounts, Allowances, Rebates & Refunds				11
12	Non-Working Officer's or Owner's Salary				12
13	Sales Tax				13
14	Non-Care Related Interest				14
15	Non-Care Related Owner's Transactions				15
16	Personal Expenses (Including Transportation)				16
17	Non-Care Related Fees				17
18	Fines and Penalties	(13,450)	19.3		18
19	Entertainment				19
20	Contributions				20
21	Owner or Key-Man Insurance				21
22	Special Legal Fees & Legal Retainers				22
23	Malpractice Insurance for Individuals				23
24	Bad Debt				24
25	Fund Raising, Advertising and Promotional	(7,663)	43.3		25
26	Income Taxes and Illinois Personal Property Replacement Tax				26
27	Nurse Aide Training for Non-Employees				27
28	Yellow Page Advertising		20.3		28
29	Other-Attach Schedule	(80,759)			29
30	SUBTOTAL (A): (Sum of lines 1-29)	$ (115,964)		$	30

OHF USE ONLY								
48		49		50		51		52

B. If there are expenses experienced by the facility which do not appear in the general ledger, they should be entered below.(See instructions.)

		1 Amount	2 Reference	
31	Non-Paid Workers-Attach Schedule*	$		31
32	Donated Goods-Attach Schedule*			32
33	Amortization of Organization & Pre-Operating Expense			33
34	Adjustments for Related Organization Costs (Schedule VII)			34
35	Other- Attach Schedule			35
36	SUBTOTAL (B): (sum of lines 31-35)	$		36
37	TOTAL ADJUSTMENTS (sum of SUBTOTALS (A) and (B))	$ (115,964)		37

*These costs are only allowable if they are necessary to meet minimum licensing standards. Attach a schedule detailing the items included on these lines.

C. Are the following expenses included in Sections A to D of pages 3 and 4? If so, they should be reclassified into Section E. Please reference the line on which they appear before reclassification. (See instructions.)

		1 Yes	2 No	3 Amount	4 Reference	
38	Medically Necessary Transport.		x	$		38
39			x			39
40	Gift and Coffee Shops		x			40
41	Barber and Beauty Shops		x			41
42	Laboratory and Radiology		x			42
43	Prescription Drugs		x			43
44	Exceptional Care Program		x			44
45	Other-Attach Schedule Laboratory	x		150	19.3	45
46	Other-Attach Schedule		x			46
47	TOTAL (C): (sum of lines 38-46)			$ 150		47

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES

A. Enter below the names of ALL owners and related organizations (parties) as defined in the instructions. Attach an additional schedule if necessary.

1 OWNERS		2 RELATED NURSING HOMES		3 OTHER RELATED BUSINESS ENTITIES		
Name	Ownership %	Name	City	Name	City	Type of Business
This work paper section is not applicable.						

B. Are any costs included in this report which are a result of transactions with related organizations? This includes rent, management fees, purchase of supplies, and so forth. [ ] YES [x] NO

If yes, costs incurred as a result of transactions with related organizations must be fully itemized in accordance with the instructions for determining costs as specified for this form.

1 Schedule V		2 Line	3 Cost Per General Ledger Item	4 Amount	5 Cost to Related Organization Name of Related Organization	6 Percent of Ownership	7 Operating Cost of Related Organization	8 Difference: Adjustments for Related Organization Costs (7 minus 4)	
1	V			$			$	$	1
2	V								2
3	V								3
4	V								4
5	V								5
6	V								6
7	V								7
8	V								8
9	V								9
10	V								10
11	V								11
12	V								12
13	V								13
14	Total			$			$	$ *	14

* Total must agree with the amount recorded on line 34 of Schedule VI.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

VII. RELATED PARTIES (continued)

C. Statement of Compensation and Other Payments to Owners, Relatives and Members of Board of Directors.

NOTE: ALL owners (even those with less than 5% ownership) and their relatives who receive any type of compensation from this home must be listed on this schedule.

	1 Name	2 Title	3 Function	4 Ownership Interest	5 Compensation Received From Other Nursing Homes*	6 Average Hours Per Work Week Devoted to this Facility and % of Total Work Week		7 Compensation Included in Costs for this Reporting Period**		8 Schedule V. Line & Column Reference	
						Hours	Percent	Description	Amount		
1	This work paper section is not applicable.								$		1
2											2
3											3
4											4
5											5
6											6
7											7
8											8
9											9
10											10
11											11
12											12
13								TOTAL	$		13

* If the owner(s) of this facility or any other related parties listed above have received compensation from other nursing homes, attach a schedule detailing the name(s) of the home(s) as well as the amount paid. THIS AMOUNT MUST AGREE TO THE AMOUNTS CLAIMED ON THE THE OTHER NURSING HOMES' COST REPORTS.

** This must include all forms of compensation paid by related entities and allocated to Schedule V of this report (i.e., management fees). FAILURE TO PROPERLY COMPLETE THIS SCHEDULE INDICATING ALL FORMS OF COMPENSATION RECEIVED FROM THIS HOME, ALL OTHER NURSING HOMES AND MANAGEMENT COMPANIES MAY RESULT IN THE DISALLOWANCE OF SUCH COMPENSATION.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

VIII. ALLOCATION OF INDIRECT COSTS

A. Are there any costs included in this report which were derived from allocations of central office or parent organization costs? (See instructions.) YES [ ] NO [x]

B. Show the allocation of costs below. If necessary, please attach worksheets.

Name of Related Organization
Street Address
City / State / Zip Code
Phone Number ( )
Fax Number ( )

	1 Schedule V Line Reference	2 Item	3 Unit of Allocation (i.e.,Days, Direct Cost, Square Feet)	4 Total Units	5 Number of Subunits Being Allocated Among	6 Total Indirect Cost Being Allocated	7 Amount of Salary Cost Contained in Column 6	8 Facility Units	9 Allocation (col.8/col.4)x col.6	
1		This work paper section is not applicable.				$	$		$	1
2										2
3										3
4										4
5										5
6										6
7										7
8										8
9										9
10										10
11										11
12										12
13										13
14										14
15										15
16										16
17										17
18										18
19										19
20										20
21										21
22										22
23										23
24										24
25	TOTALS					$	$		$	25

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE

A. Interest: (Complete details must be provided for each loan - attach a separate schedule if necessary.)

	1	2		3	4	5	6	7	8	9	10	
	Name of Lender	Related**		Purpose of Loan	Monthly Payment Required	Date of Note	Amount of Note		Maturity Date	Interest Rate (4 Digits)	Reporting Period Interest Expense	
		YES	NO				Original	Balance				
	A. Directly Facility Related Long-Term											
1	A.C. Church Hail Assistance	x		Building Addition			$ 338,534	$ 199,599		0.0225	$ 5,053	1
2												2
3												3
4												4
5												5
	Working Capital											
6	Bluestem National Bank		x	Operating		22-Dec-03	100,000			0.0340	302	6
7												7
8												8
9	TOTAL Facility Related						$ 438,534	$ 199,599			$ 5,355	9
	B. Non-Facility Related*											
10	A.C. Church Hail Assistance	x		Building Addition			861,466	507,920		0.0225	12,859	10
11												11
12												12
13												13
14	TOTAL Non-Facility Related						$ 861,466	$ 507,920			$ 12,859	14
15	TOTALS (line 9+line14)						$ 1,300,000	$ 707,519			$ 18,214	15

16) Please indicate the total amount of mortgage insurance expense and the location of this expense on Sch. V. $ None Line # _____

* Any interest expense reported in this section should be adjusted out on page 5, line 14 and, consequently, page 4, col. 7. (See instructions.)

** If there is ANY overlap in ownership between the facility and the lender, this must be indicated in column 2. (See instructions.)

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

IX. INTEREST EXPENSE AND REAL ESTATE TAX EXPENSE (continued)

B. Real Estate Taxes

Important, please see the next worksheet, "RE_Tax". The real estate tax statement and bill must accompany the cost report.

1. Real Estate Tax accrual used on 2003 report.	$	1
2. Real Estate Taxes paid during the year: (Indicate the tax year to which this payment applies. If payment covers more than one year, detail below.)	$	2
3. Under or (over) accrual (line 2 minus line 1).	$	3
4. Real Estate Tax accrual used for 2004 report. (Detail and explain your calculation of this accrual on the lines below.)	$	4
5. Direct costs of an appeal of tax assessments which has NOT been included in professional fees or other general operating costs on Schedule V, sections A, B or C. (Describe appeal cost below. Attach copies of invoices to support the cost and a copy of the appeal filed with the county.)	$	5
6. Subtract a refund of real estate taxes. You must offset the full amount of any direct appeal costs classified as a real estate tax cost plus one-half of any remaining refund. TOTAL REFUND $ _____ For _____ Tax Year. (Attach a copy of the real estate tax appeal board's decision.)	$	6
7. Real Estate Tax expense reported on Schedule V, line 33. This should be a combination of lines 3 thru 6.	$	7

Real Estate Tax History:

Real Estate Tax Bill for Calendar Year:		
1999		8
2000		9
2001		10
2002		11
2003		12

	FOR OHF USE ONLY		
13	FROM R. E. TAX STATEMENT FOR 2003	$	13
14	PLUS APPEAL COST FROM LINE 5	$	14
15	LESS REFUND FROM LINE 6	$	15
16	AMOUNT TO USE FOR RATE CALCULATION	$	16

NOTES:

1. Please indicate a negative number by use of brackets( ). Deduct any overaccrual of taxes from prior year.
2. If facility is a non-profit which pays real estate taxes, you must attach a denial of an application for real estate tax exemption unless the building is rented from a for-profit entity. This denial must be no more than four years old at the time the cost report is filed.

IMPORTANT NOTICE

TO: Long Term Care Facilities with Real Estate Tax Rates **RE:** 2003 REAL ESTATE TAX COST DOCUMENTATION

In order to set the real estate tax portion of the capital rate, it is necessary that we obtain additional information regarding your calendar 2003 real estate tax costs, as well as copies of your real estate tax bills for calendar 2003.

Please complete the Real Estate Tax Statement below and forward with a copy of your 2003 real estate tax bill to the Department of Public Aid, Office of Health Finance, 201 South Grand Avenue East, Springfield, Illinois 62763.

Please send these items in with your completed 2004 cost report. The cost report will not be considered complete and timely filed until this statement and the corresponding real estate tax bills are filed. If you have any questions, please call the Office of Health Finance at (217) 782-1630.

2003 LONG TERM CARE REAL ESTATE TAX STATEMENT

FACILITY NAME Fairview Haven, Inc. COUNTY Livingston

FACILITY IDPH LICENSE NUMBER 0008524

CONTACT PERSON REGARDING THIS REPORT Rick Plattner

TELEPHONE (815) 692-2572 FAX #: (815) 692-4257

A. Summary of Real Estate Tax Cost

Enter the tax index number and real estate tax assessed for 2003 on the lines provided below. Enter only the portion of the cost that applies to the operation of the nursing home in Column D. Real estate tax applicable to any portion of the nursing home property which is vacant, rented to other organizations, or used for purposes other than long term care must not be entered in Column D. Do not include cost for any period other than calendar year 2003.

	(A) Tax Index Number	(B) Property Description	(C) Total Tax	(D) Tax Applicable to Nursing Home
1.			$	$
2.			$	$
3.			$	$
4.			$	$
5.			$	$
6.			$	$
7.			$	$
8.			$	$
9.			$	$
10.			$	$
		TOTALS	$	$

B. Real Estate Tax Cost Allocations

Does any portion of the tax bill apply to more than one nursing home, vacant property, or property which is not directly used for nursing home services? _____ YES _____ NO

If YES, attach an explanation & a schedule which shows the calculation of the cost allocated to the nursing home. (Generally the real estate tax cost must be allocated to the nursing home based upon sq. ft. of space used.)

C. Tax Bills

Attach a copy of the original 2003 tax bills which were listed in Section A to this statement. Be sure to use the 2003 tax bill which is normally paid during 2004.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

X. BUILDING AND GENERAL INFORMATION:

A. Square Feet: 22,213 B. General Construction Type: Exterior Brick Frame Block Number of Stories One

C. Does the Operating Entity? [x] (a) Own the Facility [ ] (b) Rent from a Related Organization. [ ] (c) Rent from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI. Those checking (c) may complete Schedule XI or Schedule XII-A. See instructions.)

D. Does the Operating Entity? [x] (a) Own the Equipment [ ] (b) Rent equipment from a Related Organization. [ ] (c) Rent equipment from Completely Unrelated Organization.

(Facilities checking (a) or (b) must complete Schedule XI-C. Those checking (c) may complete Schedule XI-C or Schedule XII-B. See instructions.)

E. List all other business entities owned by this operating entity or related to the operating entity that are located on or adjacent to this nursing home's grounds (such as, but not limited to, apartments, assisted living facilities, day training facilities, day care, independent living facilities, nurse aide training facilities, etc.) List entity name, type of business, square footage, and number of beds/units available (where applicable).

F. Does this cost report reflect any organization or pre-operating costs which are being amortized? [ ] YES [x] NO
If so, please complete the following:

1. Total Amount Incurred:
2. Number of Years Over Which it is Being Amortized:
3. Current Period Amortization:
4. Dates Incurred:

Nature of Costs:
(Attach a complete schedule detailing the total amount of organization and pre-operating costs.)

XI. OWNERSHIP COSTS:

A. Land.

	1 Use	2 Square Feet	3 Year Acquired	4 Cost	
1	Nursing Home	90,000	1962	$ 6,422	1
2					2
3	TOTALS	90,000		$ 6,422	3

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Beds*	FOR OHF USE ONLY	2 Year Acquired	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
4	57		Jan-62	Jan-62	$ 145,220	$ 2,904	50	$ 2,904	$	$ 121,282	4
5	8		Mar-99	Mar-99	354,656		39	9,094	9,094	47,887	5
6											6
7											7
8											8
	Improvement Type**										
9	Additions 65-66			Jul-65	258	5	50	5		199	9
10	Additions 66-67			Jul-66	2,116	42	50	42		1,604	10
11	Additions 67-68			Jul-67	13,436	269	50	269		9,947	11
12	Additions 69-70			Jul-69	1,893	38	50	38		1,327	12
13	Additions 71-72			Jul-71	26,066	521	50	521		17,200	13
14	Additions 72-73			Jul-72	6,314	126	50	126		4,038	14
15	Additions 77-78			Jan-78	4,507	90	50	90		2,387	15
16	Sprinkler System			May-79	42,306	846	50	846		21,293	16
17	Generator Room			May-79	8,460	169	50	169		4,256	17
18	Additions 78-79			Jan-79	1,578	32	50	32		809	18
19	Driveway Asphalt			Aug-78	1,475		10			1,475	19
20	Generator			Sep-79	19,921		25	797	797	19,789	20
21	Smoke Detector			May-80	6,529	261	25	261		6,310	21
22	Lights			Jun-80	4,260	142	30	142		3,419	22
23	Additions 79-80			Jul-79	3,516	70	50	70		1,755	23
24	Smoke Detector			Aug-80	1,575		15			1,575	24
25	Additions 80-81			Jan-81	16,207	324	50	324		7,616	25
26	Porch Enclosure			Sep-81	9,453	189	50	189		4,316	26
27	Dining Room Lighting			Sep-81	2,838	95	30	95		2,164	27
28	Lobby Lighting			Dec-81	763	25	30	25		570	28
29	Linen Exhaust Fan			Jan-82	376		10			376	29
30	Sprinkler System			Feb-82	1,977	40	50	40		891	30
31	Room D2 Addition			Feb-82	432	9	50	9		197	31
32	Room B14 Addition			May-82	2,380	48	50	48		1,059	32
33	Exhaust Fan			Jun-82	322		10			322	33
34	New Roof			Jul-82	3,582		10			3,582	34
35	New Air Conditioner			Jul-82	2,590		10			2,590	35
36	Remodel Kitchen & Dining Room			Mar-83	8,205	164	50	164		3,500	36

*Total beds on this schedule must agree with page 2.

**Improvement type must be detailed in order for the cost report to be considered complete.

See Page 12A, Line 70 for total

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
37	New Sign	Jun-83	$ 994	$	10	$	$	$ 994	37
38	Landscape	Jul-83	1,455	49	30	49		1,024	38
39	Attic Fan	Dec-83	1,381		10			1,381	39
40	Kitchen Cabinets & Fixtures	Dec-83	619	13	20	13		619	40
41	Social Service Office	Feb-84	227	5	50	5		97	41
42	Outside Light Fixture	Feb-84	437		10			437	42
43	Blacktop Drive & Trees	Jan-66	2,750		10			2,750	43
44	Laundry Room	Jan-78	14,944	299	50	299		7,820	44
45	Trees	Jan-84	920		10			920	45
46	Concrete Drive	Jan-85	4,199		10			4,199	46
47	Remodeling Activity Rm & D-Wing	Jan-86	167,304	8,365	20	8,365		153,361	47
48	Remodeling C-Wing Bath, Restroom Pilot Lights, D-Wing	Jan-87	8,585	287	30	286	(1)	5,161	48
49	Courtyard--Original Set-up	Jun-87	19,000	633	30	633		10,816	49
50	Remodel Linen Rm, Exit Lights, Utility, Wardrobe Shelves, Nursing St	Jan-88	21,731	764	17	1,281	517	20,936	50
51	Courtyard	Apr-88	1,827	61	30	61		991	51
52	Patio Roof	Jul-89	2,576	129	20	129		2,063	52
53	Attic Ceiling	Jan-90	452		10			452	53
54	New Roof	Jun-91	21,664	867	25	867		11,270	54
55	Plumbing-New Faucets-Resident Rooms	Mar-92	6,148		10			6,148	55
56	Carport-Entryway Cover	Dec-92	15,403	1,027	15	1,027		12,923	56
57	Kitchen Remodeling	Apr-92	173,371	7,274	25	6,935	(339)	79,798	57
58	Office Remodel	Apr-94	20,943	838	25	838		8,589	58
59	Kitchen Remodeling & Cabinets	Oct-93	14,811	816	10		(816)	14,811	59
60	Kitchen Door, Trees, Carpet	Jan-94	2,855	190	15	190		1,986	60
61	Sewer Extension	Feb-95	2,697	180	15	180		1,680	61
62	Room B-1 & Drug Room Remodel	Feb-95	833	33	25	33		308	62
63	Replace Main Sprinkler System	Apr-95	2,550	170	15	170		1,563	63
64	Repair Dining Room Ice Machine Wall	Mar-96	948	38	25	38		315	64
65	Front Parking Lot & Sidewalk	Nov-95	20,675	1,378	15	1,378		11,938	65
66	Door Alarm System	May-95	6,226		7			6,226	66
67	Ceiling Mount Smoke Detectors-Resident Rms	Sep-95	183		7			183	67
68	Nurse Call System	Apr-95	27,948	2,994	7		(2,994)	27,948	68
69	Ceiling Mount Smoke Detectors-Resident Rms	Jun-96	3,211		7			3,211	69
70	TOTAL (lines 4 thru 69)		$ 1,263,078	$ 32,819		$ 39,077	$ 6,258	$ 696,653	70

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12A, Carried Forward		$ 1,263,078	$ 32,819		$ 39,077	$ 6,258	$ 696,653	1
2	Draperies	Jan-97	1,086	82	7	79	(3)	1,086	2
3	Phone System	May-97	12,981	1,298	10	1,298		9,299	3
4	Fire Alarm System	Mar-97	324	31	7	33	2	324	4
5	Door Alarm System	Mar-97	439	44	7	40	(4)	439	5
6	Ceiling Mount Smoke Detectors-Resident Rms	Jan-97	191	14	7	16	2	191	6
7	Door Alarm System	Dec-96	724	43	7	46	3	724	7
8	Courtyard Landscaping	Aug-96	649	43	15	43		340	8
9	Window Coverings	Feb-98	1,798	257	7	257		1,647	9
10	Intercom System	Apr-98	15,310	2,187	7	2,187		13,661	10
11	Nurse Call System	Nov-97	2,148	307	7	307		2,045	11
12	Fire Alarm System	Apr-98	744	106	7	106		662	12
13	Telephone System	Oct-97	461	66	7	66		445	13
14	Smoke Detectors	Jan-99	108	15	7	15		83	14
15	Bathroom Sprinkler System	May-00	1,873	125	15	125		510	15
16	Sink	Jan-00	746	107	7	107		481	16
17	Water Heater	Aug-99	6,669	667	10	667		3,278	17
18	Water Heater	Mar-01	3,647	365	10	365		1,205	18
19	B Wing Air Conditioner	Sep-00	1,623	232	7	232		888	19
20	Dry Pendants - Shower room	Aug-00	2,762	276	10	276		1,069	20
21	Nurses Station Carpet	Sep-00	1,151	115	10	115		436	21
22	Large Capacity Water Heater	May-01	5,290	529	10	529		1,674	22
23	Telephone System	Mar-02	853	122	7	122		282	23
24	Air Conditioning Unit	May-02	1,730	173	10	173		368	24
25	Nurse Call System	Jan-02	64,740	6,474	10	6,474		15,626	25
26	Draperies	Feb-03	1,243	124	10	124		174	26
27	Phone System Wiring	Aug-02	1,496	214	7	214		408	27
28	Water Cooler	May-03	526	75	7	75		81	28
29	Lightning Arrestors	Nov-02	1,175	117	10	118	1	196	29
30	Eyewash Station	Dec-02	884	88	10	88		139	30
31	Firecode Updates	Dec-02	4,850	323	15	323		510	31
32	Activity Draperies	May-03	662	66	10	66		71	32
33	Concrete Improvements	Jun-03	4,566	304	15	304		328	33
34	TOTAL (lines 1 thru 33)		$ 1,406,527	$ 47,808		$ 54,067	$ 6,259	$ 755,323	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

B. Building Depreciation-Including Fixed Equipment. (See instructions.) Round all numbers to nearest dollar.

	1 Improvement Type**	3 Year Constructed	4 Cost	5 Current Book Depreciation	6 Life in Years	7 Straight Line Depreciation	8 Adjustments	9 Accumulated Depreciation	
1	Totals from Page 12B, Carried Forward		$ 1,406,527	$ 47,808		$ 54,067	$ 6,259	$ 755,323	1
2	Plumbing rough-in for tub	Apr-04	955	24	10	24		24	2
3	Window Blinds	Jan-04	643	38	7	39	1	39	3
4	Kitchen Grease Trap	Jul-03	738	68	10	70	2	70	4
5	Driveway	Jun-04	4,504	25	15	24	(1)	24	5
6	Sprinkler System Air Compressor	May-04	1,090	18	10	14	(4)	14	6
7	Kitchen Grease Trap	Oct-03	2,561	128	15	125	(3)	125	7
8	Bath Tub	Dec-03	12,232	714	10	674	(40)	674	8
9	Time Clock System	Jun-04	20,175	240	7	118	(122)	118	9
10	D-Wing Fire Safety Drywall	Dec-03	421	11	20	10	(1)	10	10
11	Light Fixtures	Dec-03	595	35	10	33	(2)	33	11
12	Air Conditioning Units - Laundry & C-Wing	Oct-03	4,222	211	15	205	(6)	205	12
13									13
14									14
15									15
16									16
17									17
18									18
19									19
20									20
21									21
22									22
23									23
24									24
25									25
26									26
27									27
28									28
29									29
30									30
31									31
32									32
33									33
34	TOTAL (lines 1 thru 33)		$ 1,454,663	$ 49,320		$ 55,403	$ 6,083	$ 756,659	34

**Improvement type must be detailed in order for the cost report to be considered complete.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XI. OWNERSHIP COSTS (continued)

C. Equipment Depreciation-Excluding Transportation. (See instructions.)

	Category of Equipment	1 Cost	Current Book Depreciation 2	Straight Line Depreciation 3	4 Adjustments	Component Life 5	Accumulated Depreciation 6	
71	Purchased in Prior Years	$ 207,459	$ 24,115	$ 24,115	$	various	$ 141,239	71
72	Current Year Purchases	53,894	4,912	4,912		various	4,912	72
73	Fully Depreciated Assets	386,531				various	386,531	73
74								74
75	TOTALS	$ 647,884	$ 29,027	$ 29,027	$		$ 532,682	75

D. Vehicle Depreciation (See instructions.)*

	1 Use	Model, Make and Year 2	Year Acquired 3	4 Cost	Current Book Depreciation 5	Straight Line Depreciation 6	7 Adjustments	Life in Years 8	Accumulated Depreciation 9	
76	Patient Transport	Ford Clubvan Triton V-10 '98	May-98	$ 46,290	$	$	$	5	$ 46,290	76
77	Patient Transport	Paint Clubvan	Apr-03	1,147	229	230	1	5	287	77
78	Patient Transport	96 Dodge Van	Aug-01	11,983	1,141	1,141		7	4,422	78
79	Patient Transport	03 Ford Bus	Feb-04	42,561	3,547	3,547		4	3,547	79
80	TOTALS			$ 101,981	$ 4,917	$ 4,918	$ 1		$ 54,546	80

E. Summary of Care-Related Assets

		1 Reference	2 Amount	
81	Total Historical Cost	(line 3, col.4 + line 70, col.4 + line 75, col.1 + line 80, col.4) + (Pages 12B thru 12I, if applicable)	$ 2,210,950	81
82	Current Book Depreciation	(line 70, col.5 + line 75, col.2 + line 80, col.5) + (Pages 12B thru 12I, if applicable)	$ 83,264	82
83	Straight Line Depreciation	(line 70, col.7 + line 75, col.3 + line 80, col.6) + (Pages 12B thru 12I, if applicable)	$ 89,348	83 **
84	Adjustments	(line 70, col.8 + line 75, col.4 + line 80, col.7) + (Pages 12B thru 12I, if applicable)	$ 6,084	84
85	Accumulated Depreciation	(line 70, col.9 + line 75, col.6 + line 80, col.9) + (Pages 12B thru 12I, if applicable)	$ 1,343,887	85

F. Depreciable Non-Care Assets Included in General Ledger. (See instructions.)

	1 Description & Year Acquired	2 Cost	Current Book Depreciation 3	Accumulated Depreciation 4	
86		$	$	$	86
87	Non-Care Assets	2,170,843	58,674	628,349	87
88					88
89					89
90					90
91	TOTALS	$ 2,170,843	$ 58,674	$ 628,349	91

G. Construction-in-Progress

	Description	Cost	
92		$	92
93			93
94			94
95		$	95

* Vehicles used to transport residents to & from day training must be recorded in XI-F, not XI-D.

** This must agree with Schedule V line 30, column 8.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XII. RENTAL COSTS

A. Building and Fixed Equipment (See instructions.)

1. Name of Party Holding Lease:

2. Does the facility also pay real estate taxes in addition to rental amount shown below on line 7, column 4?
If NO, see instructions. ☐ YES ☐ NO

		1 Year Constructed	2 Number of Beds	3 Original Lease Date	4 Rental Amount	5 Total Years of Lease	6 Total Years Renewal Option*	
3	Original Building:				$			3
4	Additions							4
5								5
6								6
7	TOTAL				$ **			7

8. List separately any amortization of lease expense included on page 4, line 34. This amount was calculated by dividing the total amount to be amortized by the length of the lease .

9. Option to Buy: ☐ YES ☐ NO Terms: *

10. Effective dates of current rental agreement:
Beginning
Ending

11. Rent to be paid in future years under the current rental agreement:

	Fiscal Year Ending	Annual Rent
12.	/2005	$
13.	/2006	$
14.	/2007	$

B. Equipment-Excluding Transportation and Fixed Equipment. (See instructions.)

15. Is Movable equipment rental included in building rental? ☐ YES ☒ NO

16. Rental Amount for movable equipment: $ 626 Description: $306.00-Dry Flotation Mattress; $320.00-AirSep Oxygen Concentrator
(Attach a schedule detailing the breakdown of movable equipment)

C. Vehicle Rental (See instructions.)

	1 Use	2 Model Year and Make	3 Monthly Lease Payment	4 Rental Expense for this Period	
17			$	$	17
18					18
19					19
20					20
21	TOTAL		$	$	21

* If there is an option to buy the building, please provide complete details on attached schedule.

** This amount plus any amortization of lease expense must agree with page 4, line 34.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIII. EXPENSES RELATING TO NURSE AIDE TRAINING PROGRAMS (See instructions.)

A. TYPE OF TRAINING PROGRAM (If aides are trained in another facility program, attach a schedule listing the facility name, address and cost per aide trained in that facility.)

1. HAVE YOU TRAINED AIDES DURING THIS REPORT PERIOD? [x] YES [ ] NO

If "yes", please complete the remainder of this schedule. If "no", provide an explanation as to why this training was not necessary.

2. CLASSROOM PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	x
COMMUNITY COLLEGE	
HOURS PER AIDE	40

3. CLINICAL PORTION:

IN-HOUSE PROGRAM	
IN OTHER FACILITY	x
HOURS PER AIDE	80

B. EXPENSES

ALLOCATION OF COSTS (d)

		1 Facility Drop-outs	2 Facility Completed	3 Contract	4 Total
1	Community College Tuition	$	$	$	$
2	Books and Supplies		584		584
3	Classroom Wages (a)		2,214		2,214
4	Clinical Wages (b)				
5	In-House Trainer Wages (c)				
6	Transportation				
7	Contractual Payments		1,790		1,790
8	Nurse Aide Competency Tests		509		509
9	TOTALS	$	$ 5,097	$	$ 5,097
10	SUM OF line 9, col. 1 and 2 (e)	$ 5,097			

C. CONTRACTUAL INCOME

In the box below record the amount of income your facility received training aides from other facilities.

$

D. NUMBER OF AIDES TRAINED

COMPLETED	
1. From this facility	12
2. From other facilities (f)	
DROP-OUTS	
1. From this facility	
2. From other facilities (f)	
TOTAL TRAINED	12

(a) Include wages paid during the classroom portion of training. Do not include fringe benefits.
(b) Include wages paid during the clinical portion of training. Do not include fringe benefits.
(c) For in-house training programs only. Do not include fringe benefits.
(d) Allocate based on if the aide is from your facility or is being contracted to be trained in your facility. Drop-out costs can only be for costs incurred by your own aides.
(e) The total amount of Drop-out and Completed Costs for your own aides must agree with Sch. V, line 13, col. 8.
(f) Attach a schedule of the facility names and addresses of those facilities for which you trained aides.

XIV. SPECIAL SERVICES (Direct Cost) (See instructions.)

	1	2	3	4	5	6	7	8	
	Service	Schedule V Line & Column Reference	Staff		Outside Practitioner (other than consultant)		Supplies (Actual or) Allocated)	Total Units (Column 2 + 4)	Total Cost (Col. 3 + 5 + 6)	
			Units of Service	Cost	Units	Cost				
1	Licensed Occupational Therapist	10a.3	hrs	$	72	$ 3,509	$	72	$ 3,509	1
2	Licensed Speech and Language Development Therapist	10a.3	hrs		16	806		16	806	2
3	Licensed Recreational Therapist		hrs							3
4	Licensed Physical Therapist	10a.3	hrs		22	852		22	852	4
5	Physician Care	39.3	visits							5
6	Dental Care	39.3	visits							6
7	Work Related Program		hrs							7
8	Habilitation		hrs							8
9	Pharmacy	39.2	# of prescrpts							9
10	Psychological Services (Evaluation and Diagnosis/ Behavior Modification)		hrs							10
11	Academic Education		hrs							11
12	Exceptional Care Program	39.2								12
13	Other (specify): Medical Supplies	39.2					12,998		12,998	13
14	TOTAL			$	110	$ 5,166	$ 12,998	110	$ 18,164	14

NOTE: This schedule should include fees (other than consultant fees) paid to licensed practitioners. Consultant fees should be detailed on Schedule XVIII-B. Salaries of unlicensed practitioners, such as nurse aides, who help with the above activities should not be listed on this schedule.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XV. BALANCE SHEET - Unrestricted Operating Fund. As of 06/30/04 (last day of reporting year)

This report must be completed even if financial statements are attached.

		1 Operating	2 After Consolidation*	
	A. Current Assets			
1	Cash on Hand and in Banks	$ 230,624	$	1
2	Cash-Patient Deposits			2
3	Accounts & Short-Term Notes Receivable-Patients (less allowance)	306,080		3
4	Supply Inventory (priced at FIFO)	16,422		4
5	Short-Term Investments			5
6	Prepaid Insurance	33,012		6
7	Other Prepaid Expenses			7
8	Accounts Receivable (owners or related parties)			8
9	Other(specify):			9
10	TOTAL Current Assets (sum of lines 1 thru 9)	$ 586,138	$	10
	B. Long-Term Assets			
11	Long-Term Notes Receivable			11
12	Long-Term Investments			12
13	Land	34,814		13
14	Buildings, at Historical Cost	3,168,913		14
15	Leasehold Improvements, at Historical Cost			15
16	Equipment, at Historical Cost	824,845		16
17	Accumulated Depreciation (book methods)	(1,879,753)		17
18	Deferred Charges			18
19	Organization & Pre-Operating Costs			19
20	Accumulated Amortization - Organization & Pre-Operating Costs			20
21	Restricted Funds			21
22	Other Long-Term Assets (specify):			22
23	Other(specify):			23
24	TOTAL Long-Term Assets (sum of lines 11 thru 23)	$ 2,148,819	$	24
25	TOTAL ASSETS (sum of lines 10 and 24)	$ 2,734,957	$	25

		1 Operating	2 After Consolidation*	
	C. Current Liabilities			
26	Accounts Payable	$ (88,951)	$	26
27	Officer's Accounts Payable			27
28	Accounts Payable-Patient Deposits			28
29	Short-Term Notes Payable	(24,394)		29
30	Accrued Salaries Payable	(113,662)		30
31	Accrued Taxes Payable (excluding real estate taxes)			31
32	Accrued Real Estate Taxes(Sch.IX-B)	(865)		32
33	Accrued Interest Payable			33
34	Deferred Compensation			34
35	Federal and State Income Taxes			35
	Other Current Liabilities(specify):			
36		(227,811)		36
37				37
38	TOTAL Current Liabilities (sum of lines 26 thru 37)	$ (455,683)	$	38
	D. Long-Term Liabilities			
39	Long-Term Notes Payable			39
40	Mortgage Payable	(707,519)		40
41	Bonds Payable			41
42	Deferred Compensation			42
	Other Long-Term Liabilities(specify):			
43				43
44				44
45	TOTAL Long-Term Liabilities (sum of lines 39 thru 44)	$ (707,519)	$	45
46	TOTAL LIABILITIES (sum of lines 38 and 45)	$ (1,163,202)	$	46
47	TOTAL EQUITY(page 18, line 24)	$ (1,571,755)	$	47
48	TOTAL LIABILITIES AND EQUITY (sum of lines 46 and 47)	$ (2,734,957)	$	48

*(See instructions.)

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XVI. STATEMENT OF CHANGES IN EQUITY

		1 Total	
1	Balance at Beginning of Year, as Previously Reported	$ 1,716,522	1
2	Restatements (describe):		2
3			3
4			4
5			5
6	Balance at Beginning of Year, as Restated (sum of lines 1-5)	$ 1,716,522	6
	A. Additions (deductions):		
7	NET Income (Loss) (from page 19, line 43)	(144,768)	7
8	Aquisitions of Pooled Companies		8
9	Proceeds from Sale of Stock		9
10	Stock Options Exercised		10
11	Contributions and Grants		11
12	Expenditures for Specific Purposes		12
13	Dividends Paid or Other Distributions to Owners	( )	13
14	Donated Property, Plant, and Equipment		14
15	Other (describe) Rounding	1	15
16	Other (describe)		16
17	TOTAL Additions (deductions) (sum of lines 7-16)	$ (144,767)	17
	B. Transfers (Itemize):		
18			18
19			19
20			20
21			21
22			22
23	TOTAL Transfers (sum of lines 18-22)	$	23
24	BALANCE AT END OF YEAR (sum of lines 6 + 17 + 23)	$ 1,571,755	24 *

* This must agree with page 17, line 47.

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XVII. INCOME STATEMENT (attach any explanatory footnotes necessary to reconcile this schedule to Schedules V and VI.) All required classifications of revenue and expense must be provided on this form, even if financial statements are attached.

Note: This schedule should show gross revenue and expenses. Do not net revenue against expense.

	1 Revenue	1 Amount	
	A. Inpatient Care		
1	Gross Revenue -- All Levels of Care	$ 2,904,429	1
2	Discounts and Allowances for all Levels	(325,158)	2
3	SUBTOTAL Inpatient Care (line 1 minus line 2)	$ 2,579,271	3
	B. Ancillary Revenue		
4	Day Care		4
5	Other Care for Outpatients		5
6	Therapy	15,803	6
7	Oxygen	11,085	7
8	SUBTOTAL Ancillary Revenue (lines 4 thru 7)	$ 26,888	8
	C. Other Operating Revenue		
9	Payments for Education		9
10	Other Government Grants		10
11	Nurses Aide Training Reimbursements		11
12	Gift and Coffee Shop	4,756	12
13	Barber and Beauty Care	1,141	13
14	Non-Patient Meals	14,821	14
15	Telephone, Television and Radio	9,515	15
16	Rental of Facility Space		16
17	Sale of Drugs		17
18	Sale of Supplies to Non-Patients		18
19	Laboratory	154	19
20	Radiology and X-Ray	44	20
21	Other Medical Services	64,742	21
22	Laundry		22
23	SUBTOTAL Other Operating Revenue (lines 9 thru 22)	$ 95,173	23
	D. Non-Operating Revenue		
24	Contributions	219,099	24
25	Interest and Other Investment Income***	7,301	25
26	SUBTOTAL Non-Operating Revenue (lines 24 and 25)	$ 226,400	26
	E. Other Revenue (specify):****		
27	Settlement Income (Insurance, Legal, Etc.)		27
28	Residential Revenue	493,591	28
28a	Other Income	(37,213)	28a
29	SUBTOTAL Other Revenue (lines 27, 28 and 28a)	$ 456,378	29
30	TOTAL REVENUE (sum of lines 3, 8, 23, 26 and 29)	$ 3,384,110	30

	2 Expenses	2 Amount	
	A. Operating Expenses		
31	General Services	969,599	31
32	Health Care	1,505,170	32
33	General Administration	829,336	33
	B. Capital Expense		
34	Ownership	161,567	34
	C. Ancillary Expense		
35	Special Cost Centers	28,618	35
36	Provider Participation Fee	34,588	36
	D. Other Expenses (specify):		
37			37
38			38
39			39
40	TOTAL EXPENSES (sum of lines 31 thru 39)*	$ 3,528,878	40
41	Income before Income Taxes (line 30 minus line 40)**	(144,768)	41
42	Income Taxes		42
43	NET INCOME OR LOSS FOR THE YEAR (line 41 minus line 42)	$ (144,768)	43

* This must agree with page 4, line 45, column 4.

** Does this agree with taxable income (loss) per Federal Income Tax Return? Yes If not, please attach a reconciliation.

*** See the instructions. If this total amount has not been offset against interest expense on Schedule V, line 32, please include a detailed explanation.

****Provide a detailed breakdown of "Other Revenue" on an attached sheet.

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XVIII. A. STAFFING AND SALARY COSTS (Please report each line separately.)
(This schedule must cover the entire reporting period.)

		1 # of Hrs. Actually Worked	2** # of Hrs. Paid and Accrued	3 Reporting Period Total Salaries, Wages	4 Average Hourly Wage	
1	Director of Nursing	2,089	2,089	$ 48,932	$ 23.42	1
2	Assistant Director of Nursing					2
3	Registered Nurses	12,956	14,187	280,197	19.75	3
4	Licensed Practical Nurses	14,841	16,430	281,069	17.11	4
5	Nurse Aides & Orderlies	48,207	51,505	554,453	10.77	5
6	Nurse Aide Trainees	369	369	2,214	6.00	6
7	Licensed Therapist					7
8	Rehab/Therapy Aides	4,890	5,310	71,858	13.53	8
9	Activity Director	1,641	1,641	19,441	11.85	9
10	Activity Assistants	2,984	3,473	32,747	9.43	10
11	Social Service Workers	2,920	3,253	36,347	11.17	11
12	Dietician					12
13	Food Service Supervisor	2,443	2,443	40,031	16.39	13
14	Head Cook					14
15	Cook Helpers/Assistants	19,141	20,288	219,208	10.80	15
16	Dishwashers					16
17	Maintenance Workers	7,566	8,141	144,256	17.72	17
18	Housekeepers	7,298	7,919	88,487	11.17	18
19	Laundry	5,385	5,793	65,801	11.36	19
20	Administrator	1,816	1,816	60,643	33.39	20
21	Assistant Administrator					21
22	Other Administrative					22
23	Office Manager					23
24	Clerical	6,238	6,332	95,708	15.11	24
25	Vocational Instruction					25
26	Academic Instruction					26
27	Medical Director					27
28	Qualified MR Prof. (QMRP)					28
29	Resident Services Coordinator					29
30	Habilitation Aides (DD Homes)					30
31	Medical Records					31
32	Other Health Care(specify)					32
33	Other(specify) Ward Clerk	2,408	2,576	27,215	10.56	33
34	TOTAL (lines 1 - 33)	143,192	153,565	$ 2,068,607 *	$ 13.47	34

* This total must agree with page 4, column 1, line 45.

** See instructions.

B. CONSULTANT SERVICES

		1 Number of Hrs. Paid & Accrued	2 Total Consultant Cost for Reporting Period	3 Schedule V Line & Column Reference	
35	Dietary Consultant	131	$ 7,328	1.3	35
36	Medical Director	44	4,400	9.3	36
37	Medical Records Consultant	36	1,440	10.3	37
38	Nurse Consultant			10.3	38
39	Pharmacist Consultant	24	1,680	10.3	39
40	Physical Therapy Consultant	55	2,974	10a.3	40
41	Occupational Therapy Consultant				41
42	Respiratory Therapy Consultant				42
43	Speech Therapy Consultant				43
44	Activity Consultant	44	2,900	11.3	44
45	Social Service Consultant	15	1,001	12.3	45
46	Other(specify)				46
47					47
48					48
49	TOTAL (lines 35 - 48)	348	$ 21,723		49

C. CONTRACT NURSES

		1 Number of Hrs. Paid & Accrued	2 Total Contract Wages	3 Schedule V Line & Column Reference	
50	Registered Nurses	73	$ 2,683	10.3	50
51	Licensed Practical Nurses	213	6,902	10.3	51
52	Nurse Aides	2,607	53,640	10.3/10a.3	52
53	TOTAL (lines 50 - 52)	2,894	$ 63,225		53

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XIX-H. SUPPORT SCHEDULE - DEFERRED MAINTENANCE COSTS (which have been included in Sch. V, line 6, col. 3).
(See instructions.)

	1	2	3	4	5	6	7	8	9	10	11	12	13
	Improvement Type	Month & Year Improvement Was Made	Total Cost	Useful Life	Amount of Expense Amortized Per Year								
					FY2001	FY2002	FY2003	FY2004	FY2005	FY2006	FY2007	FY2008	FY2009
1			$		$	$	$	$	$	$	$	$	$
2													
3													
4													
5													
6													
7													
8													
9													
10													
11													
12													
13													
14													
15													
16													
17													
18													
19													
20	TOTALS		$		$	$	$	$	$	$	$	$	$

Facility Name & ID Number Fairview Haven, Inc. STATE OF ILLINOIS # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XIX. SUPPORT SCHEDULES

A. Administrative Salaries

Name	Function	Ownership %	Amount
			$
Rick Plattner	Administrator	-0-	60,643
TOTAL (agree to Schedule V, line 17, col. 1)			
(List each licensed administrator separately.)			$ 60,643

B. Administrative - Other

Description	Amount
	$
TOTAL (agree to Schedule V, line 17, col. 3)	$
(Attach a copy of any management service agreement)	

C. Professional Services

Vendor/Payee	Type	Amount
Paul Kelson, CPA	Accounting	$ 1,405
F.R. & R.	Consulting	335
Robert Rein, CPA	Consulting	5,975
Gardner & White	Accounting	1,815
Duane, Morris et al	Legal	13,550
Metz - Stoller	Surety	207
Adjustments		13,550
Reclassifications		202
TOTAL (agree to Schedule V, line 19, column 3)		
(If total legal fees exceed $2500 attach copy of invoices.)		$ 37,039

D. Employee Benefits and Payroll Taxes

Description	Amount
Workers' Compensation Insurance	$ 46,244
Unemployment Compensation Insurance	1,208
FICA Taxes	149,503
Employee Health Insurance	173,210
Employee Meals	
Illinois Municipal Retirement Fund (IMRF)*	
Employee Pension Plan	40,289
Employee Life/Disability	28,650
Employee Flexible Spending	(1,328)
Employee Physicals, Hep. B.	1,607
Employee Appreciation	20,570
TOTAL (agree to Schedule V, line 22, col.8)	$ 459,953

E. Schedule of Non-Cash Compensation Paid to Owners or Employees

Description	Line #	Amount
		$
TOTAL		$

* Attach copy of IMRF notifications

F. Dues, Fees, Subscriptions and Promotions

Description	Amount
IDPH License Fee	$ 70
Advertising: Employee Recruitment	4,392
Health Care Worker Background Check	492
(Indicate # of checks performed 41)	
Life Services Network of IL	3,773
Dues & Licenses	715
Subscriptions & Newspapers	796
Less: Public Relations Expense	( )
Non-allowable advertising	(1,218)
Yellow page advertising	( )
TOTAL (agree to Sch. V, line 20, col. 8)	$ 9,020

G. Schedule of Travel and Seminar**

Description	Amount
Out-of-State Travel	$
Staff	
Administration	
In-State Travel	
Staff	1,660
Administration	929
Seminar Expense	
Staff	6,040
Administration	2,145
Entertainment Expense	( )
TOTAL (agree to Sch. V, line 24, col. 8)	$ 10,774

**See instructions.

Facility Name & ID Number Fairview Haven, Inc. # 0008524 Report Period Beginning: 07/01/03 Ending: 06/30/04

XX. GENERAL INFORMATION:

(1) Are nursing employees (RN,LPN,NA) represented by a union? No

(2) Are there any dues to nursing home associations included on the cost report? Yes
If YES, give association name and amount. Life Services Network of IL 3,773

(3) Did the nursing home make political contributions or payments to a political action organization? No If YES, have these costs been properly adjusted out of the cost report? Yes

(4) Does the bed capacity of the building differ from the number of beds licensed at the end of the fiscal year? No If YES, what is the capacity?

(5) Have you properly capitalized all major repairs and equipment purchases? Yes
What was the average life used for new equipment added during this period? 6.56

(6) Indicate the total amount of both disposable and non-disposable diaper expense and the location of this expense on Sch. V. $ 24,474 Line 10.2

(7) Have all costs reported on this form been determined using accounting procedures consistent with prior reports? Yes If NO, attach a complete explanation.

(8) Are you presently operating under a sale and leaseback arrangement?
If YES, give effective date of lease. No

(9) Are you presently operating under a sublease agreement? YES x NO

(10) Was this home previously operated by a related party (as is defined in the instructions for Schedule VII)? YES NO x If YES, please indicate name of the facility, IDPH license number of this related party and the date the present owners took over.

(11) Indicate the amount of the Provider Participation Fees paid and accrued to the Department of Public Aid during this cost report period. $ 34,587
This amount is to be recorded on line 42 of Schedule V.

(12) Are there any salary costs which have been allocated to more than one line on Schedule V for an individual employee? No If YES, attach an explanation of the allocation.

(13) Have costs for all supplies and services which are of the type that can be billed to the Department of Public Aid, in addition to the daily rate, been properly classified in the Ancillary Section of Schedule V? Yes

(14) Is a portion of the building used for any function other than long term care services for the patient census listed on page 2, Section B? No For example, is a portion of the building used for rental, a pharmacy, day care, etc.) If YES, attach a schedule which explains how all related costs were allocated to these functions.

(15) Indicate the cost of employee meals that has been reclassified to employee benefits on Schedule V. $ Has any meal income been offset against related costs? Yes Indicate the amount. $ 14,821

(16) Travel and Transportation
a. Are there costs included for out-of-state travel? No
If YES, attach a complete explanation.
b. Do you have a separate contract with the Department to provide medical transportation for residents? No If YES, please indicate the amount of income earned from such a program during this reporting period. $
c. What percent of all travel expense relates to transportation of nurses and patients? 100%
d. Have vehicle usage logs been maintained? Yes
e. Are all vehicles stored at the nursing home during the night and all other times when not in use? Yes
f. Has the cost for commuting or other personal use of autos been adjusted out of the cost report? Yes
g. Does the facility transport residents to and from day training? No
Indicate the amount of income earned from providing such transportation during this reporting period. $

(17) Has an audit been performed by an independent certified public accounting firm? No
Firm Name: The instructions for the cost report require that a copy of this audit be included with the cost report. Has this copy been attached? If no, please explain.

(18) Have all costs which do not relate to the provision of long term care been adjusted out out of Schedule V? Yes

(19) If total legal fees are in excess of $2500, have legal invoices and a summary of services performed been attached to this cost report? Yes
Attach invoices and a summary of services for all architect and appraisal fees.